

Medicaid Freedom of Choice (FOC) List For Waiver Services PROVIDER REQUEST

Please Check One:

- ☐ New FOC Request
- ☐ Update existing FOC information
- ☐ Notification of Agency Closure: Effective date of Closure: ____/____/____

Please Print/Type ALL Information Requested:

Provider Name: _____

Provider Address: _____

Provider Contact Name & Title: _____

Provider Phone Number: (____) _____ Fax # (____) _____

Provider Toll-Free Phone Number: _____

Provider Email Address: _____

Please place/update/remove the above named agency on/from the Freedom of Choice (FOC) list for the provider type(s) checked below:

- | | |
|---|------------------|
| <input type="checkbox"/> (82) Personal Care Attendant (PCA) – (Elderly Disabled Adult [EDA] Waiver) | Region(s): _____ |
| <input type="checkbox"/> (82) Personal Care Attendant (PCA) – (New Opportunities Waiver [NOW]) | Region(s): _____ |
| <input type="checkbox"/> (89) Supervised Independent Living (SIL) – (NOW) | Region(s): _____ |
| <input type="checkbox"/> (83) Center-Based Respite - (NOW) | Region(s): _____ |
| <input type="checkbox"/> (84) Substitute Family Care - (NOW) | Region(s): _____ |
| <input type="checkbox"/> (98) Supported Employment – (NOW) | Region(s): _____ |
| <input type="checkbox"/> (13) Pre Vocational – (NOW) | Region(s): _____ |
| <input type="checkbox"/> (14) Day Habilitation – (NOW) | Region(s): _____ |
| <input type="checkbox"/> (15) Environmental Modifications – (NOW & EDA) | Region(s): _____ |
| <input type="checkbox"/> (16) Personal Emergency Response System (PERS) – (NOW & EDA) | Region(s): _____ |
| <input type="checkbox"/> (17) Medical Equipment and Supplies (Assistive Devices) – (NOW) | Region(s): _____ |
| <input type="checkbox"/> (44) Skilled Nursing – (NOW) | Region(s): _____ |
| <input type="checkbox"/> (03) Children's Choice (Children's Choice Waiver) | Region(s): _____ |

Provider's Signature & Title: _____ **Date:** _____

It is the **Provider's responsibility** to notify the Louisiana Department of Health and Hospitals (DHH), Bureau of Community Supports and Services (BCSS), regarding any changes in the above noted information within ten (10) days of the change(s). To keep from being removed from the FOC list, a provider's license and enrollment must be kept current. This notice will **NOT** notify Unisys Provider Enrollment, and/or Licensing regarding these changes.

*Please mail the following: 1.) **Completed FOC Form**, 2.) A **copy** of your current license(s), and 3.) A **copy** of your Medicaid Provider Enrollment Letter(s) (*Must submit all applicable licenses & Provider Letters with FOC) to:

Address: BCSS Provider Enrollment Section
446 N. 12th Street
Baton Rouge, LA 70802-4613

OR Fax to: (225) 219-0201 or (225) 219-0202

Reissued 12/21/04

Replaces all Previous Issuances

BCSS-PF-04-012

Louisiana Department of Health and Hospitals (DHH)
Bureau of Community Supports and Services (BCSS)
Provider Enrollment Checklist

Handout 32

Type of Enrollment:

- ☐ Initial Enrollment (New Providers)
☐ Annual Re-Enrollment

Initial Site Visit Date: _____ Follow Up Visit Date: _____
 Annual Site Visit Date: _____ Follow Up Visit Date: _____

Check all applicable Provider Type(s) and indicate if New or Annual Enrollment:

- | | | | |
|--|---|--|---|
| New Annual | New Annual | New Annual | New Annual |
| <input type="checkbox"/> <input type="checkbox"/> (82) PCA (NOW) | <input type="checkbox"/> <input type="checkbox"/> (14) Day Hab (NOW) | <input type="checkbox"/> <input type="checkbox"/> (84) Substitute Family Care (NOW) | <input type="checkbox"/> <input type="checkbox"/> (03) Children's Choice (CC) |
| <input type="checkbox"/> <input type="checkbox"/> (82) PCA (EDA) | <input type="checkbox"/> <input type="checkbox"/> (13) Pre Voc (NOW) | <input type="checkbox"/> <input type="checkbox"/> (83) Centered-Based Respite (NOW & CC) | |
| <input type="checkbox"/> <input type="checkbox"/> (89) SIL (NOW) | <input type="checkbox"/> <input type="checkbox"/> (98) Supported Employment (NOW) | <input type="checkbox"/> <input type="checkbox"/> (44) Skilled Nursing (NOW) | |

Important Note: In order to be processed, this checklist must be returned to the BCSS within sixty (60) calendar days after attending an Initial/Annual PEO workshop.

Agency Name:	DHH Region:
Agency Address:	Agency Phone No:
Agency Fax No:	Agency Email Address:
Agency Administrator and Title:	

§101 Provider Requirements

Standard Identifier	Standard/Requirement	Compliance Self-Assessment	FOR BCSS USE ONLY List of Findings/Deficiencies
A.	<p>In order to be reimbursed by the Louisiana Medicaid Program, a service provider agency must comply with all requirements of the Provider Standards of Participation, Rule, LR 29:1829, September 2003 and agrees to abide by all policies and regulations of the Louisiana Medicaid Program.</p> <ul style="list-style-type: none"> Provider has a signed copy on file of Louisiana's Medicaid Program Provider Enrollment Agreement (PE-50) indicating provider's acceptance and agreement to comply with all Medicaid laws, regulations, and conditions, including but not limited to Provider Standards of Participation Provider has a current, readily available copy of the appropriate waiver provider manual(s) for each waiver service they provide. Check box for Provider Manual(s) you currently have: <input type="checkbox"/> NOW, <input type="checkbox"/> CC, <input type="checkbox"/> EDA 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> **Not Compliant **List the "Standard Identifier" not met below and a brief description of findings (i.e., why Standard is not considered met) <u>Findings/Deficiencies</u>

B. General Provisions			
B., 1.	<p>Providers enrolled with the Department of Health and Hospitals (DHH) as a Home and Community-Based Waiver (HCBW) service provider on the effective date of this rule (<i>September 20, 2003</i>) shall have two years to comply with these standards, including attending the Bureau of Community Supports and Services (BCSS) provider orientation for HCBW prior to requesting a provider enrollment visit by the BCSS.</p> <ul style="list-style-type: none"> Existing provider (enrolled prior to 9/20/03) has attended a Provider Enrollment Orientation (PEO) workshop as evidenced by a current Annual PEO Certificate of Attendance. This standard applies ONLY to those providers who were enrolled on the effective date of this rule (9/20/03) 	<input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> N/A <input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies
B., 2.	<p>If a provider is not accessible in their DHH geographical region, individuals and/or their families may seek a provider outside of the DHH region with prior approval of BCSS (<i>Approval will be granted by the BCSS on a case-by-case basis, contingent on assessment of available services in the region</i>).</p> <ul style="list-style-type: none"> Provider has policies and procedures in place for meeting this standard, including protocols for documenting approval and service provision in the individualized Service Plan as noted on the individual's approved Comprehensive Plan of Care (CPOC) and Freedom of Choice Form (FOC). 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies
B., 3.	<p>Providers are responsible for submitting written notification by certified mail to BCSS and Medicaid of any changes in address and/or telephone numbers within 10 days of change (<i>Failure to submit timely notification to BCSS and Medicaid regarding changes may result in delay/denial of payment</i>).</p> <ul style="list-style-type: none"> Provider has policies and procedures in place for submitting written notification by certified mail to BCSS and Medicaid of any changes in address and/or telephone numbers within ten (10) days of the change. (Notification to BCSS will not automatically notify Medicaid, and/or licensing agencies. Provider is responsible for notifying all applicable agencies when changes occur.) 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies <hr/>
B., 4.	<p>In addition to internal employer reporting requirements, the provider has developed policies and procedures for employees or consultants/contractors of the enrolled provider who witness, learn of, are informed of, or otherwise have reason to suspect that an incident of abuse, neglect, or exploitation has occurred, to report such incidents in accordance with BCSS critical incident reporting, child and/or adult protection laws, and fully cooperate with the investigation of the incident.</p> <ul style="list-style-type: none"> Provider has policies, procedures in place for timely notification and reporting of incidents of suspected, and/or actual abuse, neglect or exploitation in accordance with BCSS critical incident reporting policies, child and/or adult protection laws, and protocols for how agency will cooperate with agencies investigating the incident. 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies <hr/>

Agency Name:	DHH Region:
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C. Physical Facilities and Equipment			
C., 1.	<p>The provider shall maintain an office site in each region (<i>DHH administrative region</i>) of operation.</p> <ul style="list-style-type: none"> Provider has an office site in each DHH region of operation. 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies
C., 1., a.	<p>Each <i>agency</i> site must house the case records and billing information for all individuals served by that office. (<i>Billing may occur at a centralized office location.</i>)</p> <ul style="list-style-type: none"> Provider has a well organized system in place addressing how recipient case records and billing records will be housed and maintained for all individuals served by each office. 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings:
C., 1., b.	<p>Each regional site must maintain a toll-free telephone line with 24-hour accessibility and manned by an answering service. The toll-free number is given to individuals at intake or at the first meeting.</p> <ul style="list-style-type: none"> List agency's toll-free telephone number below: _____ Toll free telephone number is activated (a working number) at time of BCSS on-site review, and continues as such for as long as provider is an enrolled HCBS waiver provider. (BCSS will call toll-free phone number during site visit, and randomly thereafter to verify compliance with this standard.) Provider has policies and procedures in place to assure the following: Person(s) assigned to answer agency's phone calls is/are knowledgeable and well informed on how to direct calls, and/or how to assist callers. Phone calls are answered in accordance with agency protocols, not as personal phone call (e.g., "ABC Provider Agency – How may I help you"). An answering/automated machine is not acceptable. Recipients know agency's toll-free phone number and are informed on procedures/protocols for accessing the agency twenty-four (24) hours a day, seven (7) days a week (including holidays),. Clearly documented protocols for expected response time to recipients/families/case managers, etc. Plan must include provisions for a supervisor/administrator to be available to direct care staff by telephone and/or beeper at all times when not on site. 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies

Agency Name:	DHH Region:
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C. Physical Facilities and Equipment

C., 1., c.	<p>The provider must have daytime office hours that conform to the usual and customary operating hours of the local business community. (<i>“Usual and Customary” means common or expected business hours in the normal course of doing business as a direct service provider agency. For example: “Open from 8a.m. to 4:30 p.m., Mon. through Friday (i.e., not part-time” business), closed on weekends. Routine Holiday closures should also be noted.</i>)</p> <ul style="list-style-type: none"> • Provider has policies and procedures in place addressing this standard. • Agency brochures, posted signs, etc. indicate office hours. 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant <u>Findings/Deficiencies</u>
C., 1., d.	<p>The provider must maintain a current brochure that outlines provider services, address and telephone numbers for distribution to the public.</p> <ul style="list-style-type: none"> • Agency brochure contain the BCSS 1-800 Help Line #: 1-800-660-0488, agency’s toll-free phone number, agency’s mission/vision, , a description of services provided by the agency, population and ages served, routine office hours, how to access services, etc. 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant <u>Findings/Deficiencies</u>
C., 2., a. – j.	<p>The provider must obtain and maintain computer equipment, Internet accessibility, and software capable of using specific software required by BCSS:</p> <ol style="list-style-type: none"> IBM-compatible PC with a Pentium 4 Processor or later version capable of using software specified by BCSS 1.44 MB 3.5 inch disc drive; 32 MB of RAM or more; 25 MB free hard drive space or more; color monitor; printer; modem (28.2k or faster); CD-ROM; Windows 95 operating system or later version; Internet account with email and web-browser software. <ul style="list-style-type: none"> • Provides has in place at the time of on-site visit, computer equipment, software and internet accessibility as noted above. • Use of Laptop computers must first be approved by the BCSS. The provider must submit this request in writing to the BCSS regional office, along with written policies and procedures on how agency will ensure HIPAA compliance of all stored participant information on Laptop computer. • The provider agency must be able to conduct business with the Department of Health and Hospitals, BCSS, and/or representatives of the Department (e.g., DHH contracted agencies who handle prior authorization and/or billing functions for the Department). 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant <u>Findings/Deficiencies</u>

Agency Name:

DHH Region:

D. Provider Training			
D., 1.	<p>New providers shall attend the BCSS provider orientation for HCBW providers and meet all required standards prior to being enrolled as a waiver service provider. BCSS provider orientation will be held in January and June, <i>or more often as deemed necessary by the BCSS. (New provides are those applying for Initial/new enrollment after September 20, 2003, LR 29:1829 Rule.)</i></p> <ul style="list-style-type: none"> New provider has attended BCSS Provider Enrollment Orientation (PEO) Workshop as evidenced by current PEO Certificate of Attendance. List date of Initial (new provider) PEO workshop: _____ 	<input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> N/A <input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant <u>Findings/Deficiencies</u>
D., 2.	<p>All enrolled providers will be required to attend an annual BCSS training conducted to continue enrollment. Additional training may be required by the BCSS if deemed necessary. <i>(Enrolled providers are those applying for Annual Re-Enrollment [not initial/new enrollment]. All providers will be required to attend an annual (from date of initial enrollment) BCSS Provider Re-Enrollment training.)</i></p> <ul style="list-style-type: none"> Enrolled provider has attended BCSS Annual Re-Enrollment Provider Enrollment Orientation (PEO) Workshop as evidenced by current Annual PEO Certificate of Attendance. List date of Annual PEO workshop: _____ 	<input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> N/A <input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant <u>Findings/Deficiencies</u>
D., 3.	<p>Those employees having direct contact with recipients must obtain no less than 16 hours of basic orientation in addition to any individualized, specialized training needed to work with a recipient on a daily basis prior to becoming solely responsible for implementing that recipient's support plan.</p> <ul style="list-style-type: none"> Policies and procedures outlining how, when, and where this training will take place, and who will provide the training is well documented. A system is in place for how employee training will be documented in the employee's personnel record, including: dates and hours of specific training, <u>trainer or presenter's name, title, agency affiliation and qualifications, etc.</u> 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant <u>Findings/Deficiencies</u>
D., 4.	<p>All providers training shall be competency-based (results driven).</p> <ul style="list-style-type: none"> Provider agency has policies and procedures in place addressing means by which training will be evaluated to measure competency/results. <i>"competency-based" means that employees can demonstrate an understanding, and have the ability to successfully perform task they were trained on. This should be evidenced by written documentation of employee evaluations, testing results, certificates of completion, employee observation, etc.</i> 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant <u>Findings/Deficiencies</u>

Agency Name:	DHH Region:
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E. Personnel and Human Resources

E., 1., a.	<p>Program or Executive Director</p> <p>a. The program director or executive director shall meet the following requirements:</p> <ul style="list-style-type: none"> i. be a registered nurse (RN) and have one year of verifiable experience in direct service work with persons with disabilities; or ii. have a bachelor's degree in a human services field (such as, but not limited to hospital or nursing home administration, physical therapy, occupational therapy, speech therapy, social work or psychology) or is currently enrolled in an accredited college and pursuing a bachelor's degree in a human services field. The individual will have a period of three (3) years (<i>from date of hire</i>) to complete the course of study; and iii. Have a minimum of one year verifiable work experience, post degree or have one year verifiable work experience while working on the degree, in planning and providing direct support to: <ul style="list-style-type: none"> (a) persons with mental retardation or other developmental disabilities; or (b) disabled adults; or elderly persons with chronic disabling illness; or • The agency must have policies, procedures and a detailed job description in place, outlining when, where and how services will be provided by this staff person to enhance the quality of individualized services and supports to waiver recipients in accordance with recipient's personal outcomes. 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies
E., 1., b.	<p>In absence of having an employee that meets the qualifications in §101.E.1, the provider must have a contract with a person so qualified to serve as program director to assure the services are delivered as described in the approved Comprehensive Plan Of Care (CPOC).</p> <ul style="list-style-type: none"> • The agency must have policies, procedures and a detailed job description in place, outlining when, where and how services will be provided by this staff person to enhance the quality of individualized services and supports to waiver recipients in accordance with recipient's personal outcomes. The BCSS reserves the right to revoke the privilege of a contracted, and/or part-time employee in this capacity if it is determined that this standard is not being met. 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies
Agency Name:		DHH Region:	

E. Personnel and Human Resources			
E., 2., a.	<p>Direct Support Staff. Direct support personnel/staff shall possess validated direct care abilities, skills and knowledge to adequately provide the care and support required by a recipient receiving waiver support services.</p> <p>a. Direct support staff is at least 18 years old and possess a high school diploma, GED, a trade school diploma in the area of human services, demonstrated competency, or have verifiable work experience in providing support to individuals with disabilities.</p> <ul style="list-style-type: none"> The above noted provider standard will take precedence over waiver specific requirements in this area (regardless of waiver type) and will be used as the standard for meeting this requirement. Agency policy and procedures shall address how the above noted criteria will be assessed, including a validation process to assure competency, and/or verifiable work experience is in place. “Verifiable” work experience means that steps have been taken to corroborate, support, validate and document stated work experience. 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies
E., 3., a. – i.	<p>The provider shall develop and implement policies and procedures for the recruitment, hiring, and retaining of qualified, competent personnel including:</p> <p>a. obtaining at least three (3) references from previous employers and/or work supervisors;</p> <ul style="list-style-type: none"> In some instances, a qualified individual (as evidenced by validated, documented direct care abilities, skills, knowledge, and etc.) may not be able to provide three (3) references from a previous employer (e.g., recently graduated from high school, had one job for several years, etc.). If this occurs, verifiable personal references may be accepted. All personal references must be from validated, documented professional sources (e.g., high school teachers, principals, counselors, clergy, etc.). References from family members, friends, etc. will not meet this requirement. <p>b. strategies to recruit and employ staff representative of the cultural and ethnic groups supported;</p> <p>c. conducting criminal background checks on all employees prior to allowing the employee to work directly with individuals receiving HCBW services; (as deemed by RS 40:1300.51-55, RS 15:587.1, and all applicable state/federal laws)</p> <p>d. strategies for retaining competent staff and staff development;</p> <p>e. compliance with Fair Labor and Child Labor laws;</p> <p>f. agency backup plans for staff coverage when direct care staff fail to report for duty as scheduled. The plan must include strategies to assure that backup direct support staff have been trained in the individualized, specialized care and support needed;</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies
Agency Name:		DHH Region:	

E. Personnel and Human Resources

E., 3., a. – i. (continued)	<p>g. Protocol outlining how the agency will have staff available during emergencies or unexpected changes in the recipient's schedule;</p> <ul style="list-style-type: none"> See BCSS-P-04-018 Memo dated 9/22/04. <p>h. a staff evaluation process that addresses the quality of the staff's support to individuals served and includes consumer satisfaction information from the recipient/guardian or authorized representative;</p> <p>i. Policies outlining the chain of command and supervisory roles including:</p> <ul style="list-style-type: none"> i. protocol for staff supervision; ii. protocol for investigation and resolution of complaints regarding the staff's performance <ul style="list-style-type: none"> Provider has policies, procedures and clearly defined protocols in place addressing each area noted above. 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies
E., 4. & E, 5.	<p>The provider must have a BCSS approved Quality Assurance/Quality Improvement (QA/QI) plan. The QA/QI plan shall include <i>specified components as outlined in Section E., #4 thru #5 of the Provider Standards of Participation Rule, LR 29:1229, September 20, 2003.</i></p> <ul style="list-style-type: none"> Date QA/QI plan submitted to BCSS: _____ Date QA/QI plan approved by BCSS: _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> *In Progress (*i.e., working with BCSS QA/QI staff)	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies
E., 6.	<p>The provider shall develop and implement system accountability for billing in keeping with generally accepted accounting principles and provide annual cost reports and requested by BCSS for systems evaluation.</p> <ul style="list-style-type: none"> Provider has policies, procedures and systems in place that address all activities necessary to ensure and demonstrate systems accountability in all agency billing practices. 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies

F. License Documentation

F., 1.	<p>The provider must adhere to all licensure regulations. The provider shall maintain a current license for all applicable areas of service provision and shall provide BCSS with current documentation of licensing in cluding all deficiencies; corrective action plans and follow-up licensing reviews.</p> <ul style="list-style-type: none"> List licensing info. below for all applicable licenses: <div data-bbox="464 938 1163 1013" style="border: 1px solid black; padding: 2px; margin-bottom: 10px;"> <p>License Type: _____</p> <p>License #: _____</p> <p>Expiration Date: _____</p> </div> <div data-bbox="464 1036 1163 1110" style="border: 1px solid black; padding: 2px; margin-bottom: 10px;"> <p>License Type: _____</p> <p>License #: _____</p> <p>Expiration Date: _____</p> </div> <div data-bbox="464 1133 1163 1208" style="border: 1px solid black; padding: 2px;"> <p>License Type: _____</p> <p>License #: _____</p> <p>Expiration Date: _____</p> </div> <ul style="list-style-type: none"> Provider has current license(s) on file with correct site address. Provider has policies and procedures/protocols in place for assuring licensing requirements are met timely, including protocols for addressing areas of deficient practice to enhance service delivery and quality. 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies
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Agency Name:

DHH Region:

F. License Documentation			
F., 2.	<p>Providers not adhering to licensing regulations and/or not attending scheduled re-enrollment (<i>i.e.</i>, <i>BCSS Annual Provider Re-enrollment training</i>) will be denied new referrals by Freedom of Choice. If the provider does not comply with these requirements, steps will be taken to un-enroll the agency as a Medicaid provider for HCBW.</p> <ul style="list-style-type: none"> The agency has policies and procedures in place reflecting protocols for meeting this standard. The agency has a current license on file. The agency has documentation showing progress toward correction of any licensing deficiencies. The agency has a current certificate of attendance to an Annual Provider Re-Enrollment Orientation Training Workshop. 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies
F., 3.	<p>Providers is operating under a provisional license or under an extended license due to noncompliance must demonstrate satisfactory progress toward correction of the deficient practices in order to maintain provider standing for continued enrollment as a waiver service provider. Providers possessing provisional licenses due to noncompliance shall be removed from the Freedom of Choice list until all deficiencies have been corrected and a full license has been obtained.</p> <ul style="list-style-type: none"> The agency has documentation on file (e.g., licensing plans of correction, memos from licensing, etc.) showing progress toward correction of any licensing deficiencies. 	<input type="checkbox"/> NA <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> NA <input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies
F., 4.	<p>Staff transporting an individual receiving HCBW services shall have a valid (current) driver's license, current liability insurance, and the vehicle shall be in safe operating condition as determined by a current inspections sticker.</p> <ul style="list-style-type: none"> Agency's policies and procedures reflect protocols, for how, when, by whom, etc. this standard is to be met (e.g., how often staff driver's license, liability insurance, inspection sticker, etc. will be checked, who will be responsible for checking and documenting this is in place, back up plans for transporting waiver participants when problems arise with workers car, license, etc.). 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies
G. Fiscal Accountability			
G., 1.	<p>The new provider (applicant) shall establish a business plan which includes cash flow projections and which has been reviewed by a fiscal entity (e.g., a CPA) who attests to the adequacy of the plan for meeting the provider's monthly overhead and payroll requirements on an ongoing basis. A notarized letter from the fiscal entity will serve as evidence and shall be available for review upon request by BCSS.</p> <ul style="list-style-type: none"> New provider has a notarized letter on file from a fiscal entity attesting to adequacy of provider's business plan to meet monthly overhead and payroll requirements on an ongoing basis (A new provider is one who enrolled after September 20, 2003). 	<input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> NA <input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies

Agency Name:	DHH Region:
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G. Fiscal Accountability			
G., 2.	<p>Existing providers shall have an established relationship with a fiscal entity (i.e., a bank) to assure fiscal stability and documentation in the form of liquid assets or the ability to secure approval for a line of credit.</p> <ul style="list-style-type: none"> Existing provider has documentation on file from a fiscal entity (i.e., bank) that shows provider is currently fiscally sound and has an established line of credit, and/or the ability to secure approval for a line of credit to cover overhead, payroll responsibilities, etc. This can be in the form of a letter from the provider's bank, and/or current cost reports from provider's bank that clearly show fiscal soundness of agency. 	<input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> NA <input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies
G., 3.	<p>Requirements for average rates of pay and/or benefit packages for direct support staff will be responsive to the overall funding of the services of the program by the DHH.</p> <ul style="list-style-type: none"> Provider has policies and procedures in place to evaluate, on an on-going basis, average rates of pay for direct support staff, and how increases in salaries, and/or benefits packages will be reflected as overall DHH funding increases. 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies
H. Records and Documentation			
H., 1.	<p>The agency shall comply with the Health Insurance Portability and Accountability Act of 1996, (HIPAA) as defined by the Centers for Medicare and Medicaid Services (CMS).</p> <ul style="list-style-type: none"> Provider has policies and procedures in place that address how the agency assures HIPAA compliance requirements as defined by the Centers of Medicare and Medicaid Services (CMS). Provider has a signed copy on file of PE-50 as evidence of provider's agreement to "adhere to all applicable federal HIPAA regulations regarding the conduct of electronic health care transactions and the protection of the privacy and security of individual health information and any additional regulatory requirements imposed under HIPAA." 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies
H., 2., a., - g.	<p>A complete and separate record for each individual served shall be maintained, including:</p> <ol style="list-style-type: none"> planning meeting minutes; comprehensive Plans of Care (CPOCs); service logs; billing records; progress notes; eligibility records; and all other pertinent documents <ul style="list-style-type: none"> Provider has policies, procedures and systems in place addressing all areas noted above. 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies

Agency Name:	DHH Region:
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H. Records and Documentation			
H., 3.	<p>The provider shall provide all case records and billing documents to BCSS as required for monitoring activities and investigations upon request on -site or within two (2) hours if records are stored off site.</p> <ul style="list-style-type: none"> Provider has policies, procedures/protocols in place addressing this standard 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies
H., 4., a. – d.	<p>The provider will maintain the following documents and provide them to BCSS upon request:</p> <ol style="list-style-type: none"> copies of the current approved CPOC, the current service plan and all CPOC revisions in the individual's case record and in the individual's home (Note: These documents must be current and available); Documentation of payroll and services delivered within a pay period must agree. Documentation of services with in a pay period will be recorded in the individual's home record (<i>Documentation of services rendered within a specific time period must agree with payroll record for that same time period</i>). updated and implemented service plan that meets the service changes warranted by the CPOC revision(s) within five (5) calendar days of receiving a copy of the approved CPOC revision; a copy of the behavior support plan, if one is required in the recipient's home. <ul style="list-style-type: none"> Provider's policies and procedures reflect how this standard will be met, including but not limited to who will be responsible for each task, meeting specific time lines, checking to assure specific documentation is in CPOC and in the recipient's home, and that payroll is consistent with when services were rendered. 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies
H., 5., a. – c.	<p>The provider shall maintain documentation to support that services were rendered as per the approved CPOC. The provider shall:</p> <ol style="list-style-type: none"> maintain documentation of the day-to-day activities of the recipient (service logs and progress notes); maintain documentation detailing the recipient's progress toward his/her personal outcome(s); maintain documentation of all interventions used to ensure the recipient's health, safety and welfare. (<i>Note: interventions may include, but are not limited to, medical consultations, environmental and adaptive interventions, etc.</i>) <ul style="list-style-type: none"> Provider policies and procedures clearly state protocols for how documentation supporting that services were rendered as per the approved CPOC, including all areas noted above are in place. Protocols should include who will be responsible for documentation, how often documentation will be reviewed, who will review, etc. 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies

Agency Name:	DHH Region:
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H. Records and Documentation			
H., 6., a. – f.	<p>The provider shall develop written policies and procedures relative to the protection of recipient's rights which include, but are not limited to:</p> <ul style="list-style-type: none"> a. human dignity/respectful communications; b. person centered planning/personal outcomes; c. community/cultural access; d. right to personally manage his/her financial affairs, unless legally determined otherwise or he/she gives informed consent; e. right to refuse service/treatment; f. civil rights (such as right to vote). <ul style="list-style-type: none"> • Policies and procedures are in place as noted above. 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies
I. Discharges & Transfers			
I., 1., a. – e.	<p>The provider's responsibilities for voluntary planned transfers, or discharges from their agency. The provider's responsibilities for voluntary planned transfers or discharges from their agency shall include:</p> <ul style="list-style-type: none"> a. Obtaining of a written request for transfer to another agency and the expected transfer date/time from the individual or his/her authorized representative; b. Notifying the recipient's case manager within 24 hours for planning to begin; c. Allowing the case manager no less than two weeks (14 calendar days) and up to 30 days (if needed) for planning the transfer, unless it is for an emergency placement; d. Participating in the planning meeting facilitated by the case manager who assures the availability of appropriate services through the receiving agency; and e. With the written consent from the recipient, both the transferring and the receiving agencies shall share responsibilities for ensuring the exchange of medical and program information which shall include: <ul style="list-style-type: none"> i. current CPOC; ii. current service plan; iii. a summary of behavioral, social, health and nutritional status; and iv. any other pertinent information. <ul style="list-style-type: none"> • The agency has established written policies and procedures/protocols for the management of participant voluntary, planned transfers, or discharges from their agency as noted above. 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies
I., 2., a. – f.	<p>The provider must have written policies and procedures for the management of involuntary transfers <i>or</i> discharges for their agency.</p> <ul style="list-style-type: none"> a. Involuntary transfers/discharges from their services may occur for the following reasons: <ul style="list-style-type: none"> i. medical protection of the well being of the individual or others; ii. emergency situations (i.e., fire or weather related damage); or iii. any direct threat to the recipient's health, safety and/or welfare. b. Involuntary transfers/discharges may occur when a provider identifies an inability to provide the services indicated in the recipient's CPOC, but only after documented reasonable accommodations have been tried and failed. <ul style="list-style-type: none"> • The agency has established written policies and procedures/protocols for the management of participant in voluntary transfers or discharges. 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies

Agency Name:

DHH Region:

I. Discharges & Transfers			
I., 2., a. – f. (continued)	<p>c. Provider responsibilities include submission of a written report to the BCSS regional office detailing the circumstances leading up to the decision for an involuntary transfer/discharge, and provision of the documentation of the provider's efforts to resolve issues encountered in the provision of services.</p> <p>d. All team conferences shall reflect a person-centered process and be conducted with the recipient, guardian or authorized representative, case manager and the appropriate provider personnel to develop or update the CPOC.</p> <p>e. The recipient, guardian or authorized representative will be notified in writing at least 15 calendar days prior to the transfer or discharge from the provider agency. The written notification shall include:</p> <ul style="list-style-type: none"> i. the proposed date of transfer/discharge; ii. the reason for the action; and iii. the names of the personnel available to assist the individual throughout the process. <p>f. The service provider has established policies, procedures and protocols for providing the recipient guardian or authorized representative with information on how to request an appeal of the decision for involuntary discharge.</p> <ul style="list-style-type: none"> i. The recipient may request reconsideration through the service provider's grievance policy and procedures. ii. The recipient may request an informal reconsideration hearing with BCSS and the discharging service provider. iii. If the recipient is not satisfied with the results of the informal reconsideration hearing, an appeal may be filed with the DHH Appeals Section by notifying the regional BCSS office or the DHH Bureau of Appeals. <ul style="list-style-type: none"> • The agency has established written policies and procedures/protocols for the management of participant voluntary, planned transfers, or discharges from their agency as noted above. 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies
J. Emergency Situations			
J., 1., a. – b.	<p>Immediate Jeopardy situations shall be handled immediately and the recipient's guardian or authorized representative, BCSS regional office, and the case manager must be notified immediately, no later than 48 hours after the provider's direct support staff, and/or the provider's administrative staff learns of the immediate jeopardy situation.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies

Agency Name:	DHH Region:
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J. Emergency Situations			
J., 1., a. – b. (continued)	<p>a. The notification shall include:</p> <ul style="list-style-type: none"> i. The anticipated action; ii. That the action will take place within 48 hours unless an emergency situation exists; and iii. The names of personnel available to assist the individual and/or their family through the process. <p>b. A critical incident report and investigation must begin as soon as possible after the individual is safe.</p> <ul style="list-style-type: none"> • The provider has developed policies and procedures/protocols for addressing Immediate Jeopardy situations in accordance with all DHH/BCSS, and applicable state and federal rules and regulations. 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies
J., 2., a. – c.	<p>Critical incidents shall be reported to all appropriate law enforcement agencies as directed by state law and as directed in the Bureau's critical incident policy and to BCSS within two (2) hours of the agency's Executive Director or his/her designated representative's first knowledge of the incident. If after business hours, a message shall be left on the BCSS toll-free line voice mail and a critical incident report must be sent via FAX on the next business day. (As outlined in BCSS Critical Incident Reporting and Compliant Policy).</p> <p>a. Critical incidents updates shall be sent to BCSS within 72 hours and a final report to BCSS up to 30 days from the incident.</p> <p>b. The waiver service provider's responsibilities for critical incident reporting are:</p> <ul style="list-style-type: none"> i. immediately assuring the recipient's health and safety; ii. reporting the incident to BCSS and the case manger; iii. conducting an internal investigation; iv. cooperating with all critical incident investigations; v. resolution of all critical incidents and complaints against the provider; and <p>c. Implement a plan of correction for problems identified in the course of critical incident investigations.</p> <ul style="list-style-type: none"> • Policies, procedures and protocols have been developed to address Critical incidents as listed above. 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies
Agency Name:		DHH Region:	

K. Recipient's Provisions and Rights			
K., 1.	<p>The center-based respite provider may serve recipients residing in other regions other than the region in which it is located. The selection should be approved by BCSS and included in the recipient's CPOC.</p> <ul style="list-style-type: none"> Centered-Based Respite provider has policies and procedures in place to address this standard. (Important note: An In-Home Respite License does not certify you to provide Center-Based Respite services. If you are not a licensed Center-Based Respite provider, check the "N/A" box in the next column.) 	<input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> N/A <input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies
K., 2., a. – c.	<p>An individual is linked to a provider for a period of six months at a time.</p> <p>a. The recipient may not transfer to a different provider until after the six -month period without "Good Cause".</p> <p>b. The provider shall not refuse to serve any individual who chooses their agency unless there is documentation to support an inability to meet the individual's health, safety and welfare needs, or all previous efforts to provide services and supports have failed and there is no option but to refuse services. The BCSS must be notified of the circumstances.</p> <p>c. Requirements in Paragraph 2. a- b can only be waived by BCSS.</p> <ul style="list-style-type: none"> The agency has established written policies and procedures for supporting participants when the agency cannot meet their health safety and welfare needs, or when all previous efforts to provide services and supports have failed. Policies and procedures include documentation of all support strategies tried, timely notification to the case manager and BCSS of circumstances leading to this action. 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies
K., 3.	<p>The BCSS toll-free help line number must be included in the contact packets left in the recipient's home.</p> <ul style="list-style-type: none"> The agency has developed an informational/contact packet that includes the BCSS toll-free help line number (1-800-660-0488) to be left in the recipient's home. 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies
K., 4., a. - d.	<p>The provider shall encourage and support the recipient in the development of the CPOC and provider service plan by:</p> <ol style="list-style-type: none"> Obtaining the recipient's personal choices, vision, and preferences and incorporating them into the individual's person-centered CPOC; Assessing the recipient's: <ol style="list-style-type: none"> Skills; Needed supports; and Health safety and welfare needs. Development of strategies to meet the recipient's service needs and timely development of the service plan to implement the strategies; and The development of a process to monitor the ongoing implementation of the plan. <ul style="list-style-type: none"> The agency has developed policies and procedures related to the development, implementation and on going monitoring of the participant's CPOC and provider Individual Service Plans that all areas noted above. 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies
Agency Name:		DHH Region:	

L. Case Management			
L., 1.- 4.	<p>Case Management. The provider shall have a written working agreement with the case management agency serving the recipient. The agreement shall include:</p> <ol style="list-style-type: none"> 1. written notification of the time frames for CPOC planning meetings; 2. the timely notification of the meeting dates and time to allow for provider participation; 3. how agencies will exchange information, such as notification of changes in the CPOC or in service delivery; and 4. assurance that the provider sends the appropriate provider representatives to the planning meetings as invited by the recipient. <ul style="list-style-type: none"> • The provider has policies and procedures in place for obtaining a written, working agreement with the case management agency serving the recipient that includes all components noted above. 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies
THIS SECTION IS FOR CHILDREN'S CHOICE PROVIDERS ONLY – If you are not applying for Initial/New or Annual CC Enrollment/Re-Enrollment – SKIP THIS SECTION.			
1.	<p>The Children's Choice (CC) provider agency agrees to provide at a minimum Family Support and Crisis Support.</p> <ul style="list-style-type: none"> • Provider has a signed copy on file of Medicaid Children's Choice Provider Enrollment Agreement (PE-50). • Provider policies and procedures address how individualized, person-centered Family Support and Crisis Support are to be provided, periodically reviewed and monitored for effectiveness. 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies
2., a. – g.	<p>The Children's Choice provider agency agrees to provide directly, or by a signed agreement with qualified agent(s) the following services as needed and approved on the recipient's CPOC</p> <ol style="list-style-type: none"> a. Centered-Based Respite: <ol style="list-style-type: none"> i Children's Choice provider is licensed by DSS and Medicaid enrolled as a Centered-Based Respite Provider: <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", list the following information: Centered-Based Respite Lic. # _____ Expiration Date: _____ ii Children's Choice provider currently has an agreement with a qualified Center-Based Respite provider to provide this service: <input type="checkbox"/> Yes <input type="checkbox"/> No – If "Yes", List Center-Based Respite Provider here: _____ iii Center-Based Respite is currently unavailable in this DHH administrative region: <input type="checkbox"/> Yes <input type="checkbox"/> No b. Family Training c. Diapers provided and reimbursed through the enrolled agency. d. Ramp-Home – Family agrees with selected provider and payment reimbursed through the enrolled provider. e. Bathroom Modifications Home – Family agrees with selected provider and payment reimbursed through the enrolled provider. f. General Adaptations Home – Family agrees with selected provider and payment reimbursed through the enrolled provider. g. Vehicle Lifts Home – Family agrees with selected provider and payment reimbursed through the enrolled provider. <ul style="list-style-type: none"> • Provider has documented, signed agreements with qualified agents who will render services noted above. Agreement must include detailed policies and procedures/protocols regarding type of services to be provided, who will provide the service, how services will accessed, timelines for delivery, approval and reimbursement of services rendered, etc. All waiver services must be documented on the individualized CPOC, and prior approved before services are rendered. 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Compliance <input type="checkbox"/> Not Compliant Findings/Deficiencies

Agency Name:	DHH Region:
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Provider Attestation:

I certify that the responses I have provided herein are true, correct and supportable by documentation to the best of my knowledge. I further understand that completion and submission of this Provider Enrollment Checklist signals my readiness for the BCSS to conduct an on-site review to verify my compliance with the Provider Standards of Participation, Rule, LR 29:1829, September 2003 for enrollment/annual re-enrollment as a provider of Medicaid reimbursed HCBW services.

Agency Authorized Representative Name and Title (Printed or Typed): _____

Agency Authorized Representative Signature: _____ Date: _____

Please have Authorized Representative sign here upon completion of site visit: **X**

For BCSS Office Use Only:**Date Enrollment/Re-Enrollment Checklist Received By BCSS:**

☐ Initial Enrollment (New Providers) Initial Site Visit Date: _____ Initial Follow Up Site Visit Date: _____
☐ Annual Re-Enrollment Annual Site Visit Date: _____ Annual Follow Up Site Visit Date: _____

Agency Name: _____ Address: _____ Region: _____

Agency Phone Number: _____ Fax: _____ Provider Type: _____

Findings/Deficiencies

- ☐ This agency was found to be in compliance with all Provider Standards of Participation on: _____ and is being recommended for Annual Provider Enrollment.
- ☐ This agency was found to be out of compliance with the Provider Standards of Participation on _____ as noted in the "Findings/Statement of Deficiencies" column of this checklist.
- ☐ This agency must submit a detailed Plan of Correction (PoC), and/or supporting documentation as specified by the BCSS to the **BCSS Regional Office** address noted below, no later than **thirty (30) calendar days** from the date of this review. _____

Mail to:

- ☐ Due to areas of non-compliance, a BCSS follow up site visit has been scheduled with your agency for the date and time noted below (thirty (30) calendar days from the date of this review). **Follow-up review: Date:** _____ **Time:** _____

Note: Providers who fail to submit an approvable plan of correction, or who do not respond at all to the BCSS within thirty (30) calendar days from the date of their Initial/Annual review will be required to attend the next scheduled PEO in Baton Rouge to start the Initial/Annual Enrollment/Re-Enrollment process over again.

Provider Acknowledgement of Receipt of BCSS Enrollment/Re-Enrollment Site Visit Findings

☐ I have received a copy of this Provider Enrollment Checklist containing enrollment/re-enrollment site visit Findings/Statement of Deficiencies and understand its content. I agree to follow through with any recommendations made as a result of BCSS enrollment/re-enrollment site visit findings.

Date Provider Agency received Findings/Statement of Deficiencies: _____

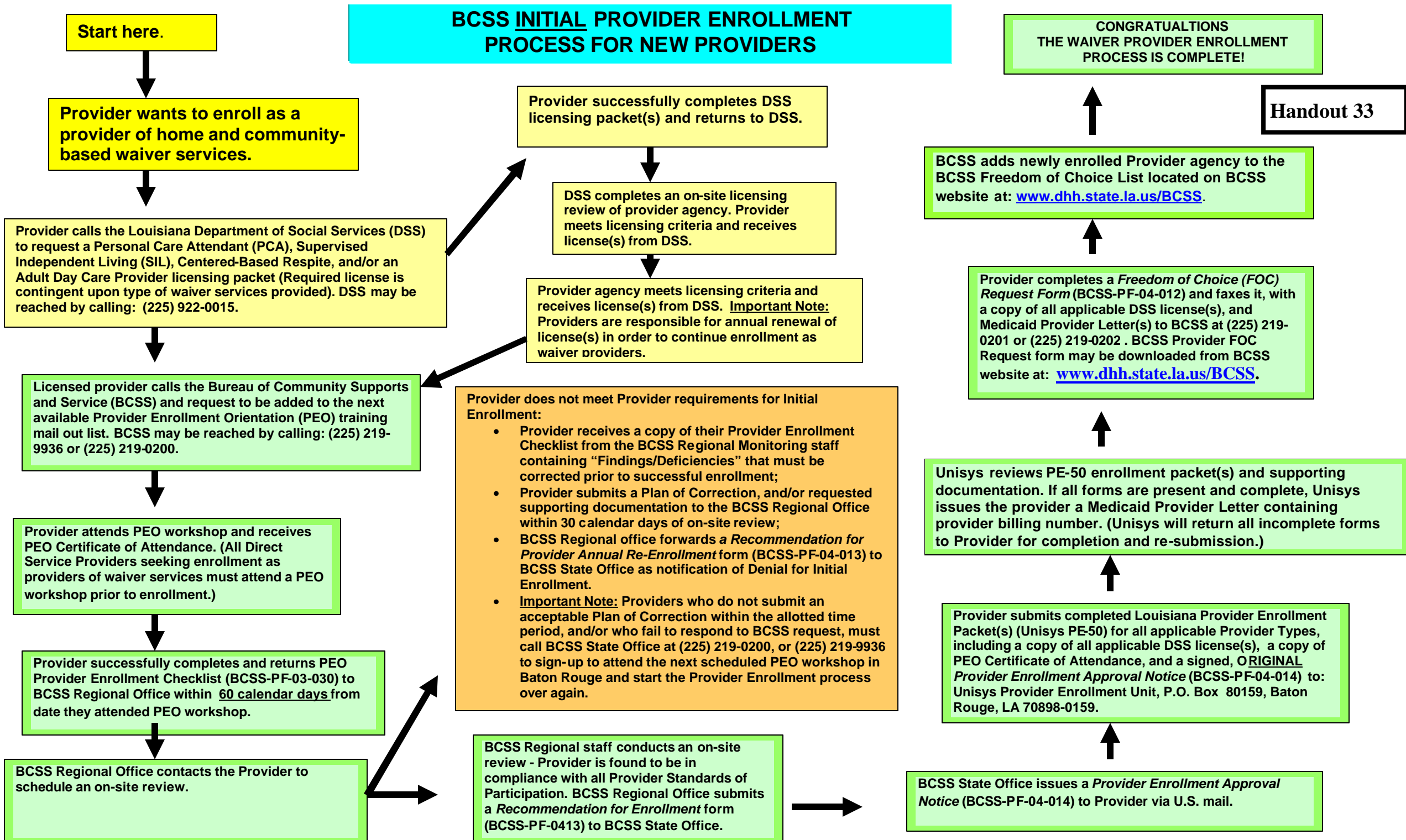
Agency Authorized Representative Name and Title (Printed or Typed): _____

Agency Authorized Representative Signature: _____ Date: _____

Signature and Title of BCSS Representative: _____ Date: _____

Agency Name: _____

DHH Region: _____



BCSS ANNUAL PROVIDER RE-ENROLLMENT PROCESS FOR CURRENTLY ENROLLED PROVIDERS

Start here.

Currently enrolled Provider receives invitation from BCSS to attend an Annual Provider Re-Enrollment Orientation (PEO) training workshop.

Provider attends mandatory BCSS Annual Re-Enrollment PEO workshop and receives PEO Certificate of Attendance.

Provider successfully completes and returns the *Provider Enrollment Checklist* (BCSS-PF-03-030) and all requested supporting documentation to the BCSS Regional Office within 60 calendar days from date they attended Annual Re-Enrollment PEO workshop.

BCSS Regional Office reviews *Provider Enrollment Checklist* (BCSS-PF-03-030) and supporting documentation to determine eligibility for Provider Re-Enrollment (Desk Audit Review).

Note: BCSS will not routinely conduct an on-site visit to determine eligibility for Provider Annual Re-Enrollment. Continued compliance with the Provider Standards of Participation will be routinely monitored by the BCSS during biannual, on-site monitoring activities, and/or as deemed necessary by the BCSS.

Important Note: All Direct Service Providers must be licensed and enrolled in each DHH Administrative Region where they are currently providing waiver services. Providers who are not currently licensed in each DHH Administrative Region where they are providing services **MUST** call the Department of Social Services (DSS) at: (225) 922-0015 to start the licensing process for those region(s) in order to successfully complete the Annual Re-Enrollment process on or before compliance deadline date of 9/20/05. Providers are responsible for annual renewal of license(s) in order to continue enrollment as waiver providers.

Provider does not meet Annual Provider Re-Enrollment requirements:

- Provider receives a copy of their submitted Provider Enrollment Checklist from the BCSS Regional Office containing "Findings/Deficiencies" that must be corrected prior to successful re-enrollment;
- Provider submits a Plan of Correction, and/or requested supporting documentation to the BCSS Regional Office within 30 calendar days of receipt of deficiency notice;
- Provider returns a signed copy of page 18 of the Provider Enrollment Checklist (BCSS-PF-03-030) via fax or U.S. mail to BCSS Regional Office within 14 calendar days of receipt of findings/deficiencies.
- BCSS Regional office forwards a *Recommendation for Provider Annual Re-Enrollment* form (BCSS-PF-04-013) to BCSS State Office as notification of Denial for Annual Re-Enrollment.
- **Important Note:** Providers who do not submit an acceptable Plan of Correction within the allotted time period, and/or who fail to respond to BCSS request, must call BCSS State Office at (225) 219-0200, or (225) 219-9936 to sign-up to attend the next scheduled PEO workshop in Baton Rouge and start the Provider Enrollment process over again.

Provider is found to be in compliance with all Provider Standards of Participation - BCSS Regional office forwards a *Recommendation for Provider Annual Re-Enrollment* form (BCSS-PF-04-013) to BCSS State Office.

BCSS State Office issues a *BCSS Annual Re-Enrollment Approval Notice form* (BCSS-PF-04-015) to the provider agency via U.S. mail notifying them of successful Annual Re-Enrollment.

An original copy of the *BCSS Annual Re-Enrollment Approval Notice form* (BCSS-PF-04-015) is kept by the Provider and I serves as proof of compliance with BCSS Annual Re-Enrollment requirements.

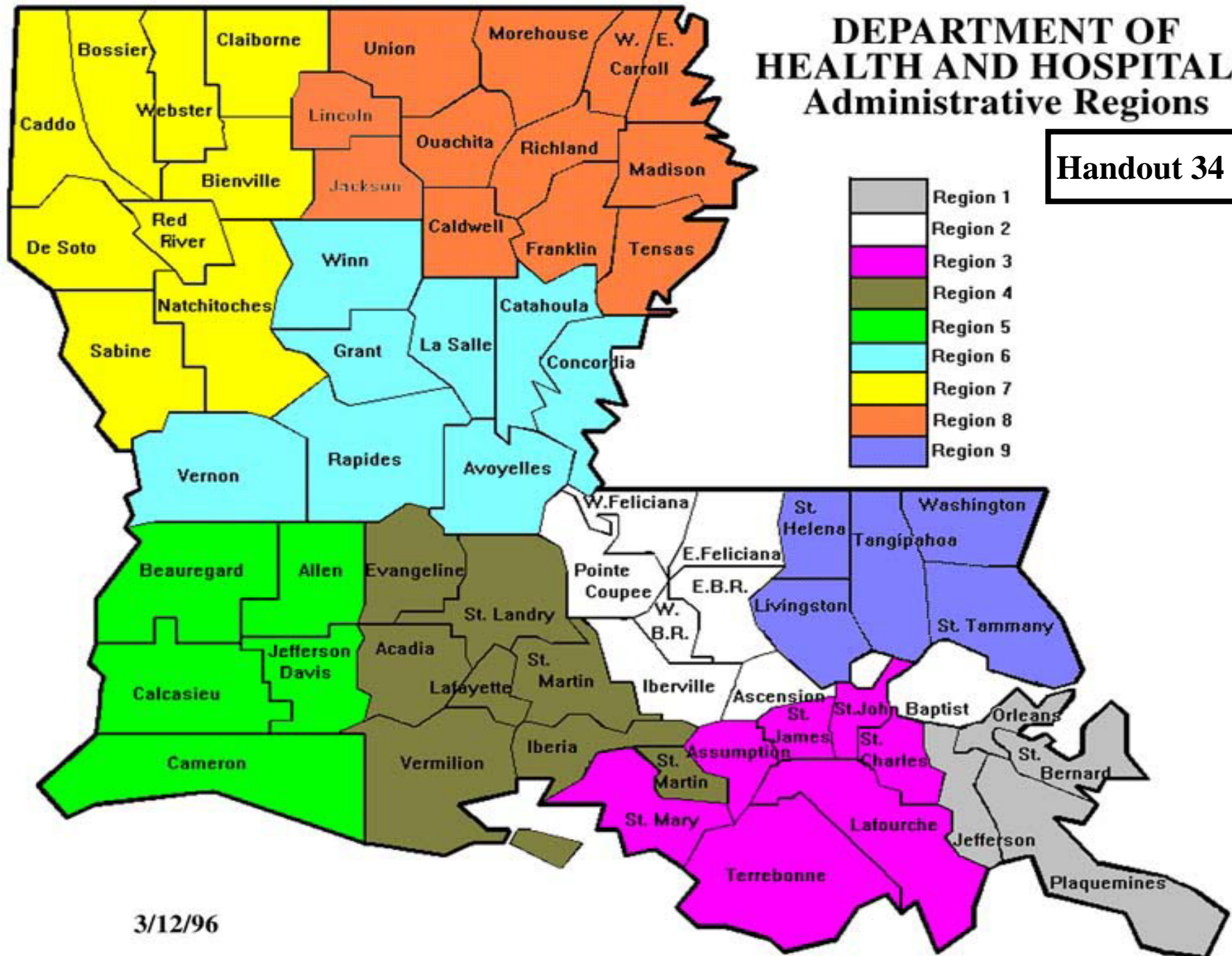
Provider updates Freedom of Choice (FOC) information as needed by completing a Provider FOC Request Form (BCSS-PF-04-012) and faxing it, along with a copy of all applicable DSS license(s) and Medicaid Provider Letter(s), to BCSS at (225) 219-0201 or (225) 219-0202. The Provider FOC Request form may be downloaded from BCSS website at: www.dhh.state.la.us/BCSS.

BCSS updates (as needed) Provider Agency information on the BCSS Freedom of Choice List located on BCSS website: www.dhh.state.la.us/BCSS

CONGRATUALTIONS
THE WAIVER PROVIDER ANNUAL RE-ENROLLMENT PROCESS IS COMPLETE!

DEPARTMENT OF HEALTH AND HOSPITALS Administrative Regions

Handout 34



3/12/96

Region 1 – New Orleans

65 East Jefferson
26 West Jefferson
36 Orleans
38 Plaquemine
44 St. Bernard

Region 3 – Thibodaux

04 Assumption
29 Lafourche
45 St. Charles
47 St. James
48 St. John
51 St. Mary
55 Terrebonne

Region 5 - Lake Charles

02 Allen
06 Beauregard
10 Calcasieu
12 Cameron
27 Jeff Davis

Region 7- Shreveport

07 Bienville
08 Bossier
09 Caddo
14 Claiborne
16 Desoto
35 Natchitoches
41 Red River
43 Sabine
60 Webster

Region 9 - Mandeville

32 Livingston
46 St. Helena
52 St. Tammany
53 Tangipahoa
59 Washington

Region 2 – Baton Rouge

03 Ascension
17 East Baton Rouge
19 East Feliciana
24 Iberville
39 Pointe Coupee
61 West Baton Rouge
63 West Feliciana

Region 4 – Lafayette

01 Acadia
20 Evangeline
23 Iberia
28 Lafayette
49 St. Landry
50 St. Martin
57 Vermillion

Region 6 – Alexandria

05 Avoyelles
13 Catahoula
15 Concordia
22 Grant
30 LaSalle
40 Rapides
58 Vernon
64 Winn

Region 8 - Monroe

11 Caldwell
18 East Carroll
21 Franklin
25 Jackson
31 Lincoln
33 Madison
34 Morehouse
37 Ouachita
42 Richland
54 Tensas
56 Union
62 West Carroll